2006

Taj Becker, M.D. v. Utah Department of Health, Division of Health Care Finance (Medicaid) : Brief of Appellant

Utah Court of Appeals

Lyle Odendahl, Mark Shurtleff; Attorneys for Appellee.
Taj Becker; appellant pro se.

CASE NO. 20060495 C.A.

IN THE UTAH COURT OF APPEALS

TAJ BECKER, M.D., Plaintiff / Appellant pro se, v. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCE (MEDICAID), Defendant / Appellees	BRIEF OF APPELLANT TAJ BECKER, M.D. Appeal from the Judgment of the Fifth District Court in and for Washington County, State of Utah – the Honorable G. Rand Beacham Civil No. 020501574 Appellate Case No. 20060495 C.A.

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ORAL ARGUMENT REQUESTED

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TABLE OF AUTHORITIES
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JURISDICTIONAL STATEMENT

The Utah Court of Appeals has jurisdiction of this matter pursuant to Section 78-2a-3(2)(j), Utah Code Annotated (1996), as amended.

STANDARD OF REVIEW

Standard of Review on a grant of a Motion to Dismiss: "...[W]e affirm only if, as matter of law, the Plaintiff could not recover under the facts alleged. And considering allegations in the complaint we take them as true and consider them and all reasonable inferences drawn therefrom in a light most favorable to the Plaintiff." Golding v. Ashley Central Irrigation Co., 793 P.2d 897, 898 (Utah 1990) citing Lowe v. Sorenson Research Co., 779 P.2d 668, 669 (Utah 1989).

NAME OF TRIAL COURT AND NATURE OF PROCEEDING

This appeal is from a final order of dismissal by the Fifth District Court in and for Washington County, State of Utah, after a one-day bench trial, the Honorable Judge R. Beacham presiding.

STATEMENT OF ISSUES ON APPEAL

FIRST ISSUE: Whether the District Court committed reversible error in its Finding of Fact (Number 6), that the Medicaid Fraud Control Unit's (MFCU hereafter) investigation of the Plaintiff was not initiated, controlled or directed by Defendant Department of Health-Division of Health Care Finance Medicaid (DOH hereafter).

SECOND ISSUE: (District Court's Conclusion of Law; Number 3): Whether the District Court erred in ruling, as a matter of law, concluding that the MFCU has never been an agent of, a designee of, or a part of the Defendant DOH-Medicaid, and further concluding (Number 4) that Federal law prohibits any MFCU agency role in behalf of Medicaid.

THIRD ISSUE: Whether the District Court erred in ruling, as a matter of law (Numbers 6,7, and 8(b)), that Medicaid's 1998-1999 conclusion of Dr. Becker's upcoding, [a felony under the Utah False Claims Act (UCA Chap. 20, 26-20-9], and transmitting this finding to the MFCU, "...did not constitute an agency action that imposed any duty on Defendant under the Provider Agreement."

FOURTH ISSUE: Whether the District Court erred in concluding, as a matter of law, that "Defendant met all its legal and contractual duties to provide Defendant (sic) due process, including notice and opportunity to be heard."

FIFTH ISSUE: Whether the District Courts interpretation of the relevant laws, federal regulations and statutory rules, which were preserved and presented to the Court during the Trial, demonstrated credible evidence that the District Court had a reasonable basis for its finding (Number 12): "...that Plaintiff has failed to prove any breach of contract by Defendant or any damages caused to Plaintiff by Defendant."

ISSUES PRESERVED

Conforming to the Utah Rules of Appellate Procedure 24(a)(5)(A) Plaintiff/Appellant submits the following reference from the District Court's trial transcript (T.T. hereafter),

showing that these issues now on appeal have been raised and preserved by testimony of witnesses and argument of counsel before the Honorable Judge Beacham during trial.

However, since the trial had been scheduled to continue the following day (T.T. pp. 290: 18-21; 316:23 to 318:20), additional issues and testimony pertaining to damages were anticipated to be raised at that time. However, the second day of the trial did not materialize due to the District Court's taking under advisement Defendant's oral Motion to Dismiss at the end of the first day of trial (T.T. 7:20) [UMAP 24(a)(5)(B), State v. Irvin, 924 P.2d 5 (Utah Ct. App. 1996, cert denied)].

1) Contrary to the District Court and Defendant's claim (T.T. 198:1-3; 199:13-21), Dr. Becker has nowhere abandoned her claims that the MFCU's activities in behalf of Medicaid were in the nature of an agent/designee. (See Complaint Exhibit C. Numbers 1, 3; T.T. 164:11-20; 165: 1-2; 164:12; 168: 21; to 169: 3; 217:19; 245:13-16). By automatically transferring Dr. Becker's billing codes- (and those of thousands of other physicians) – to the MFCU without the MFCU's written request specifically identifying the provider M.D., -Medicaid thereby initiated the MFCU's criminal investigation which was based solely on that supplied information. (T.T. 164:15; 167:15-19; 168:25 et. seq.; 205: 14-19; 206:4-7; 208:13-25). Defendant never controverted Dr. Becker's claim confirmed to her initially by MFCU prosecutor/counsel Assistant Attorney General Denis Kroll, - that Utah DOH's Division of Health Care Finance-Medicaid (DHCF hereafter) Director Mr. Michael Deily had initiated the investigation (T.T. 168:25-to-169:3).

2) Dr. Becker continues to aver that a special agency relationship of cooperation and collaboration between the MFCU and Medicaid exists as mandated by federal regulation (e.g. 42 CFR 455.21). When Medicaid chooses to use an MFCU for its law enforcement component, the MFCU becomes indeed a part of the Medicaid program. The common custom that they are "distinct' or 'separate' for their individual budget allocations and specified authority parameters does not proscribe a special purpose principal-agent relationship. While Medicaid programs exist without an optional MFCU, no MFCU can possibly exist without a state Medicaid program. Moreover, Medicaid retains ultimate control over the MFCU because they may sever their relationship upon 60-day notice without cause thereby terminating the MFCU's existence. (T.T. 216:15 to 217:19; 218:20; 219:1-6).

3) The District Court's finding that Medicaid's early 1998-1999 disclosure to the MFCU which found Dr. Becker to have 'upcoded' (overbilled) did not "...trigger any duty upon the Defendant...to conduct its own investigation", is not based on any fact, statute, rule or regulation and neither the Court below nor the Defendant have cited any.

On the contrary, CFR § 455.14 and 455.21 as part of the contract unambiguously mandates that Medicaid "must" begin administrative action by informing Dr. Becker of any alleged overpayments alleged by "any" source, and request prompt restitution. (T.T. 274:2-9; 287:10-15; 300:25-to-303:15; 306:12-16; 309:12 to 310:20).

The mandated request for an immediate disclosure and 'prompt" repayment is not only in conformance with the agreement (Contact B-2) itself, but reflects public policy

and that of the Office of Inspector General (OIG hereafter) that an indicated or proven overcharging by providers of Medicaid should be halted at once to prevent further abuse of the severely limited Medicaid resources intended for needy patient's medical care.

4) For the above-stated reasons, Dr. Becker disputes the District Court's conclusions of law Number 11: "Defendant met all it legal and contractual duties..." That conclusion simply ignores the promised – all important 'prompt' time frame for a preliminary examination of the allegation against a provider, prior to or concurrent to any litigation against Dr. Becker stretching from 1998 to 2002. When the federally mandated preliminary administrative investigation was finally granted to Dr. Becker it was done after the State's dismissal (with prejudice) of the State's claim against Dr. Becker and led to a quick decision exonerating Dr. Becker (T.T. 306:12-16; 308:3-10; 310:14-to-311:13).

Thus had Medicaid met its obligation to respond promptly it would have saved four years of needless litigation and hundreds of thousands of dollars expended by both parties.

Dr. Becker alleges that the District Court evidenced no reasonable basis to its holding and thereby abused its discretion in its conclusion of law, resulting in an arbitrary and capricious decision.

5) In recognition of Dr. Becker's preserved arguments and surprise witness testimony at trial, the facts of the case and cited statutes, considering the Federal Regulations, state rules and the language of the written contractual agreement itself, Dr. Becker has

preserved abundant facts and issues justifying her Breach of Contract claim vs. Defendant (T.T. 309:12-to-311:13).

The standard of review remains identical to op cit. under STANDARD OF REVIEW.

STATEMENT OF THE CASE

Of necessity, the following statements are largely parallel to those already forwarded in Dr. Becker's Motion for a New Trial and Docketing Statement, included as documents transferred to the Appellate Court.

In November, 1998, Taj Becker, M.D. (Neurology) was served by the Utah MFCU with a facially legal Subpoena Duces Tecum in Aid of a Criminal Investigation, requiring her to release numerous of her private patients' medical documents (charts) to the MFCU. The MFCU had represented itself during settlement negotiations as acting in behalf of Medicaid (See Exhibit C of Complaint). Dr. Becker was advised by the MFCU's prosecutor and legal counsel that the Utah Department of Health-Medicaid had initiated the criminal investigation (T.T. 169:1-4).

The MFCU routinely downloaded Medicaid's entire provider database for coding analysis of medical practice billing patterns. Such misleading inconclusive data-mining was specifically prohibited to the MFCU by CFR 42 § 1007.19(e)(2), which for sound reasons reserved this very difficult function to be performed by the medically-trained coding staff of the Medicaid program Integrity Unit (T.T. 25:12-14; 26:106; 42 CFR § 455.13).

The MFCU, untrained in medical coding, diagnostics, and pharmacology, alleged that Dr. Becker's coding was at a higher level than the medical notations in her charts indicated and demanded immediate repayments of over $100,000 or face criminal charges and fines of $680,000 plus costs if she did not pay quickly.

Later lesser and lesser amounts (down to $27,000) were demanded during MFCU settlement proposals prior to any charges filed in court.

Dr. Becker denied all allegations of faulty coding and immediately requested that the MFCU share a copy of their subpoenaed medical charts containing the alleged miscoding with Medicaid's professionally trained experts in its Program Integrity Unit (PIU hereafter) where she could meet her prompt 'burden of proof' in reliance on the contractual promise (p. B-2 of the Contract). The MFCU did not then indicate that they would do so or at any time thereafter until surprisingly six years later under oath at trial, in September 2006.

During that trial testimony, both MFCU counsel/prosecutor Kroll and Medicaid PIU Director Gatzemeier unequivocally testified that an MFCU request for a PIU evaluation was indeed acted upon at that time (1998-1999). However, the exchange of information between Medicaid and the MFCU incriminating Dr. Becker was kept from her knowledge, and its occurrence denied throughout the following years.

Moreover, Dr. Becker, at the same time in early 1999, had also independently made the same request for a preliminary investigation-hearing by self-referral to Medicaid's PIU which specifically employs coding experts mandated for this purpose by federal regulations (T.T. 25:12-14; 42 CFR § 455.12). Such clarifying self-

referrals by providers on controversial coding interpretations are encouraged by Medicaid, which has 'educational' obligations by CFR rules for this very purpose.

Medicaid's PIU Director Gatzemeier declined to afford Dr. Becker a preliminary investigation, claiming disingenuously that Medicaid was legally prevented from doing so until the MFCU had concluded their investigation or litigation.

In April-May 1999 the MFCU's prosecutor/counsel, Asst. Attorney Denis Kroll, submitted several monetary proposals to Dr. Becker in order to settle out of court, prior to filing any action against her.

The MFCU in numerous written statements always represented itself as 'Medicaid". On May 5, 1999, Dr. Becker rejected to proposals in a letter to Mr. Kroll (Contract Exhibit D).

A civil suit was then filed by State v. Becker (June 24, 1999) after she refused to pay the MFCU's erroneous extrapolated money demands. The civil suit was dismissed without prejudice shortly thereafter (July 8, 1999).

Subsequently, a criminal action (Second Degree Felony) was filed by the State upon the MFCU's information on January, 11, 2000 based exclusively on the identical single issue of alleged wrong coding dismissed in the civil case. Medicaid PIU Director, Steven Gatzemeier, was listed as a witness for the State in the felony action against Dr. Becker. That case was likewise dismissed by the State with prejudice on September 6, 2000.

Thereafter, in December 2000, approximately three years after her first requests, and after the criminal action's dismissal, Medicaid finally wrote Dr. Becker alleging

that going back several years she was overpaid by approximately $5,000, and demanding restitution of that sum.

Dr. Becker contested that demand. She was only then permitted by Medicaid to make a written request for the previously denied hearing in answer to Medicaid's letter since Medicaid had informed Dr. Becker in 1999 that they could not and would not review her coding pending the MFCU investigation.

Dr. Becker was thereby able to participate in her long sought administrative process in order to settle the coding disagreement and to clear her name. However, for the next one and one-half year, Medicaid's PIU was as yet unprepared to assemble the required administrative process and the hearing did not materialize until finally adjudicated in May 16, 2002, when Dr. Becker was exonerated by Medicaid's own Administrative Law Judge, Lambertus Jansen, and found to owe no repayments for alleged upcoding.

A year previous, on May 21, 2001, Dr. Becker had already filed a Notice of Claim with the State alleging, inter alia, Breach of Contract by Medicaid. The State did not reply.

This case on Appeal was filed by Dr. Becker v. DOH-Medicaid on August 14, 2002. After many delays, on September 28, 2005, a scheduled one and one-half day trial was cut short to one day when the District Court took an oral motion made by counsel for the Defendant during trial under advisement.

Defendant Medicaid requested the District Court to grand a Motion to Dismiss or a direct verdict. The Court did not order Memoranda on Defendant Medicaid's

Motion to Dismiss (T.T. 291:16-19). The District Court did not continue the trial on the issue of damages as scheduled for the next day. On February 3, 2006, the Honorable Fifth District Judge signed his Order of Dismissal, granting Defendant's motion without further hearing or Memoranda.

Subsequently, on February 13, 2006, Dr. Becker filed a Motion for a New Trial based upon heretofore undisclosed surprise trial testimony by State witnesses Medicaid PIU Director Steven Gatzemeier and MFCU Assistant Attorney Denis Kroll during trial.

Again, despite Mr. Gatzemeier's previous years-long insistence to Dr. Becker, asserting that a legal prohibition barred him from reviewing her coding while the MFCU was investigating (T.T. 148:8-to-149:10), testimony at trial disclosed, un-controverted by Defendant, that Medicaid had in fact, contrary to his denials to Dr. Becker, in "late 1998 or in early 1999", responded to an MFCU request by reviewing Dr. Becker's medical records and informing the MFCU that Dr. Becker had 'upcoded' according to his PIU staff analysis (T.T. 40:4-16).

This critical collaboration between the MFCU and Medicaid was not disclosed in Dr. Becker's discovery requests from Medicaid in the case at bar.

Medicaid and the MFCU frankly admitted that Mr. Gatzemeier's claim of inability to perform Medicaid's obligation to afford Dr. Becker a prompt opportunity to meet her burden of proof (concurrent with MFCU investigation), was based on no rule or law (T.T. 92:15-25; 274:2-9).

According to the binding federal rules, this Medicaid reported findings of wrongful overpayments to Dr. Becker "must" promptly trigger the CFR mandated preliminary investigation and hearing requested by Dr. Becker in conformance to the contract promises.

Medicaid had deliberately suppressed this finding, in bad faith. This was done as a matter of convenience, callously and with indifference to Dr. Becker's administrative rights under the contract, as Medicaid passively awaited the outcome of litigation. If Dr. Becker had been convicted or frightened enough by threats of criminal prosecution to pay without an opportunity to review the specific allegations to meet her burden of proof, Medicaid would have received alleged money restitution (50% of which they later acknowledged NEVER having paid to Dr. Becker) plus very large penalties without having to acknowledge any involvement in the case. Such outcome would have been extremely desirable for Medicaid since it seeks to maintain the appearance of a provider friendly relationship with physicians, which are increasingly difficult to find for participation in the Medicaid program.

In fact, Medicaid would have received tens of thousands of dollars of 'restitution' that Medicaid had admittedly never paid to Dr. Becker.

Moreover, Medicaid's PIU Director Gatzemeier informed Dr. Becker in early 1999, after Dr. Becker requested of him that Medicaid review her coding, that the PIU was under-funded and unable to perform any but the most minimal federally mandated post payment review of providers, less than one-half of one percent (T.T. 152:4-19). For this and other reasons, in 1985, Medicaid had constructively delegated

this crucial function to the MFCU, which had no expertise in these very difficult medical coding requirements (T.T. 26:6), and, unlike Medicaid, is not mandated by federal rule to conduct administrative reviews. This resulted in foreseeable harmful consequences to Dr. Becker who was given no notice of this material change to the contract terms, which essentially nullified promised 'prompt' administrative procedures 'on the lowest level' (Contract B-2, CFR § 455.14 & 455.21; Utah Administrative Code Rule 410-14-1; Utah Code un-annotated 63-46b-1(4)).

The PIU's incriminating allegation to the MFCU regarding Dr. Becker, later conclusively adjudicated in Dr. Becker's favor as having no merit, was arrived at unilaterally by Medicaid, and in secret without Dr. Becker's contractually promised input or opportunity to provide her "...burden of proof to substantiate services provided to Title XIX/UMAP recipients."

Dr. Becker's Motion for a New Trial was denied and she filed a Notice of Appeal to the Utah Supreme Court May 19, 2006, which was transferred to the Honorable Utah Court of Appeals on June 16, 2006.

Medicaid knew that its disclosure of alleged 'upcoding' would provide substantial impetus to the MFCU's decision to charge Dr. Becker. She was forced to spend years, and hundreds of thousands of dollars in her successful defense, proximately caused by Medicaid's refusal to allow a prompt examination of the allegation at the lowest level which would have settled the issue administratively some three years earlier as it eventually did and without litigation (T.T. 300:4-12; 274:2-9).

The chief issue on appeal is whether the District Court below committed substantial prejudicial and reversible error, by discounting the crucial early timeliness of the mandated preliminary review performance as Medicaid's obligation and covenanted duty, which is clearly memorialized in the four corners of the contract agreement, and additionally in the inclusive contact-defining and binding Provider Manual, the Federal/State Acts, Laws, Rules and Regulations upon which Dr. Becker had every reason and duty to rely in good faith and fair dealing.

The DOH must take full responsibility for their lack of good faith performance. As the 2nd Restatement of the Law on Contract § 205 d states succinctly:

> "Subterfuge and evasion violate the obligation of good faith of performance even though the actor believes his conduct to be justified. But the obligation goes further; bad faith may be overt or may consist of inaction, fair dealing may require more than honesty." [emphasis added]

Neither the Defendant, DOH-Medicaid, nor the District Court, could cite a single law, rule or regulation, which would have prevented Medicaid from fulfilling its early obligation under the law. This was conceded by Assistant Attorney General Kroll and PIU Director Gatzemeier at trial (T.T. 42:5-to-43:22; 275:5-13).

Apparently, the main basis of the District Court's decision was the Honorable Judge's finding that none of the Contract's mandated statutory or regulatory administrative procedures evidence a Medicaid duty to act "promptly" or at the "lowest level". The Court agreed with the Defendant's argument that prior to a written request to Dr. Becker, originating at Medicaid's discretion and demanding overpayment restitution from her, nothing obligated Medicaid to initiate any

administrative action with the participation of the accused requesting such procedure in writing after being civilly or criminally implicated by Medicaid.

Dr. Becker has fully demonstrated this to be an erroneous prejudicial misreading of the law as cited and a substantial reversible error.

Dr. Becker was prevented from tendering a written request for an administrative review on her alleged miscoding to Medicaid's PIU Director Gatzemeier upon his assurance to her that such request to him would be futile and legally impossible while the MFCU investigation was in process. He also stated that he had no knowledge of the MFCU's doings and had no involvement in their investigation. Both statements are contrary to the facts as clearly revealed at trial (T.T. 55:1-3; 44:17; 48:1-6).

Medicaid had a principal-agent relationship with the MFCU. In the alternative, the MFCU was an 'apparent' agent acting in behalf and for the benefit of Medicaid.

Therefore, by Dr. Becker's written request to the MFCU-designee in 1998-99 for a concurrent preliminary administrative investigation by Medicaid-PIU on the upcoding charge she alleges to have made that request constructively to Medicaid itself.

Marveon Sign Co. v. Roebuck, 694 P.2d 604 (Utah 1984):

"If a contract is made with a known agent acting within the scope of his authority for a disclosed principal, the contract is that of the principal and the agent cannot be held liable thereon."

Even if the Honorable Court of Appeals sustains the lower Court's negative finding on the agency issue, there remains the newly discovered and un-controverted

fact revealed by defendant during trial that Medicaid itself communicated an incriminating finding to the MFCU in 1998-99.

This fact simplifies Dr. Becker's claim of breach of contract enormously, making the agency claim a supporting, but not an imperative issue in the case at the bar.

STATEMENT OF THE FACTS
(The Parties)

Plaintiff/Appellant Taj Becker, M.D. is a practicing, licensed physician, Board Certified in Neurology, and she is a natural born citizen of the United State of America (hereafter Dr. Becker).

Dr. Becker completed her Bachelors (B.A.) in 1974 at the University of California, Berkeley; Medical School in 1978 at Creighton University of Nebraska, attended Ph.D. Neurosciences studies at the UCLA Brain Research Institute, completed her Neurology Residency and subsequent two-year Spinal Cord Fellowship at Stanford University in 1985. After completing a locum tenens in the California Bay Area (Los Altos) she and her husband moved to Hawaii.

She served there as adjunct professor of Medicine at the John Burns School of Medicine and maintained a private neurology practice in Hawaii until moving to St. George, Utah in 1994 where she has a private solo practice, served as Chief of Medicine at Dixie Regional Medical Center and Trustee for the Utah Medical Association.

Defendant/Appellee is the Utah Department of Health, Division of Health Care Finance-Medicaid (hereinafter Medicaid). The Utah Department of Health is a

Department of the Executive Branch of the Utah State Government. Through its Division of Health Care Finance, the Department of Health administers the Medicaid program, which is financed by the State. Utah receives a portion of this expenditure from the Federal Center for Medicare and Medicaid Services (CMS-Former HCFA) under the Social Security Act. This funding process applies also to the MFCU, which was likewise an entity of the Executive Branch (Department of Public Safety). Neither Medicaid nor the MFCU personnel are thereby agents of the federal government.

On August 14, 2002, Dr. Becker filed this Breach of Contract case against the defendant in the Fifth District Court in and for Washington County, Utah (Judge G. Rand Beacham).

On September 28, 2005, a bench trial was held, both parties being represented by counsel. Upon an oral motion to dismiss made by Defendant DOH, the court took the motion under advisement without reconvening the trial as scheduled and expected by Dr. Becker.

On February 3, 2006, the District Court Judge signed the Order of Dismissal on the merits, granting defendant Medicaid's motion.

On February 13, 2006, Dr. Becker, now pro se, filed a Motion for a New Trial.

On April 26, 2006, that Motion was denied by the District Court.

On May 19, 2006, a Notice of Appeal to the Utah Supreme Court was filed by Dr. Becker, followed with a timely request for the full trial transcript and filing of the Docketing Statement with certified copies to all parties.

On June 11, 2006, Dr. Becker was notified that the Utah Supreme Court transferred her appeal to the Utah Court of Appeals (20060495 S.C. now 200060495 C.A.).

Dr. Becker submits to the Honorable Utah Appellate Court this Brief of the Plaintiff/Appellant with certified copies to all parties.

SUMMARY OF ARGUMENT

A contract (of adhesion) existed between Dr. Becker and Medicaid-DOH.

The four corners of that agreement significantly expanded and defined the parties obligations and rights by reference to the binding Title XIX of the Social Security Act, Utah Medical Assistance Program (UMAP), Code of Federal Regulations (CFR), Utah Administrative Code Rule 410-14-1, Provider Manuals, updates, information bulletins and other related material (Provider Agreement: A-2, B7).

The most specific Federal Regulations relevant to the Provider and Medicaid is the CFR as recognized by the Defendant (T.T. 105:14-20; 107:13-17; 109:10-18).

In addition, the binding Provider Manual's Section 5 "PROVIDER COMPLIANCE AND HEARING RIGHTS" specifically addresses available administrative procedures and remedies for the provider physicians under Utah's Administrative Procedure Act.

A time frame requiring a prompt Medicaid professional administrative preliminary investigation/hearing upon allegations 'from any source' relating to the extremely

complex medical coding issues was a contractual bargained-for promise of material importance to Dr. Becker.

> UCC (Utah Commercial Code)
> 70A-2-210. Delegation of Performance-Assignment of Rights. (1) A party may perform his duty through a delegate unless otherwise agreed or unless the other party has a substantial interest in having his original promisor perform or control the acts requires by the contract. No delegation of performance relieves the party delegating of any duty to perform or any liability for breach.

Medicaid's willful and legally unsupported failure to perform this requested absolute duty was against fair dealing and good faith, and in breach of contract, - forseeably damaging to Dr. Becker (Beck v. Farmers Ins. Exch., 701 P.2d 795, 801, Utah 1985.

The District Court took judicial notice of the cited relevant CFR requirements, the Utah Administrative Procedure Act and other DOH policies and regulations, which are all defining and binding parts of the contract.

Even if Dr. Becker's earlier circumstantially compelled reliance on the AGENCY relationship would be found to lack sufficient merit by the Honorable Court of Appeals, the surprise state witness testimony at trial admitting the early 1998-9MFCU-Medicaid active collaboration, establishes undeniable facts to find Medicaid directly and independently in breach. Trial counsel for Dr. Becker adequately preserved this claim at trial (T.T. 301:1-6; 304: 1-6; 303:23).

The Defendant's and District Court's failure to cite any laws or regulations in contradiction of the legislative intent to afford an opportunity to an aggrieved provider for administrative relief "...prior to or during litigation", renders the Order of Dismissal a

substantial and reversible error, and prejudicial to Dr. Becker (State v. Jacques, 924 P.2d 898, 902 (UT. Ct. App. 1996).

The Trial Court's finding that Medicaid, by its refusal to comply with Dr. Becker's early and insistent requests for a preliminary investigation on her coding (See CFR § 455.14) met all its covenanted duties, - is legally and factually insufficient to support that finding and without a reasonable basis, even when viewed in a light most favorable to the trial court's decision (See State v. Pena, 869 P.2d 932, 935-36 (Utah 1994).

The trial court incorrectly interpreted the plain language of the contract (B-2) and its pertinent included CFR regulations, state acts and implicit rules, and thereby abused its discretion.

> Court of Appeals of Utah 871 P.2d 552, 234 Utah Adv. Rep. 19:
> [64] "Utah recognizes, as a general principle of contract law, that "every contract is subject to an implied covenant of good faith" Brehany v. Nordstrom, Inc., 812 P.2d 49, 55-56 (Utah 1991). Accord St. Benedict's Development Co. v. St. Benedict's Hosp., 811 P.2d 194, 199 (Utah 1991) ("covenant of good faith and fair dealing inheres in most, if not all contractual relationships"). Furthermore, the violation of the duty of good faith and fair dealing "gives rise to a claim of breach of contract." Beck v. Farmers Exchange, 701 P.2d 795, 798 (Utah 1985). The state has waived immunity "as to any contractual obligation" (Utah Code Ann. 63-30-5).

ARGUMENT

STANDARD OF REVIEW on grant of a Motion to Dismiss: "...[W]e affirm only if, as matter of law, the Plaintiff could not recover under the facts alleged. And considering allegations in the complaint we take them as true and consider them and all reasonable inferences drawn therefrom in a light most favorable to the Plaintiff." Mountain Am. Credit Un. v. McClellan, 854 P.2d 590, 591 (Utah Ct. App.), cert denied, 862 P.2d 1356 Utah 1993).

POINT I: MEDICAID BY ITS MFCU AGENT INITIATED DR. BECKER'S CODING INVESTIGATION.

POINT II: THE MFCU FUNCTIONED IN BEHALF OF THE UTAH MEDICAID PROGRAM IN THE ROLE OF A SPECIAL OR APPARENT AGENT

The District Court's conclusions in denying Points I and II are so closely related that it is practical to examine them together.

MARSHALLING THE PRO-COURT ARGUMENT

Since the District Court did not cite specific law or regulations supporting its decision in its Order of Dismissal, Dr. Becker can only reluctantly speculate on its legal foundation, - in the light most favorable to the District Court, - which may have led to court to its finding of facts and conclusions of law.

Defendant Medicaid argued at trial and elsewhere that 42 CFR part V § 1007.9(a), (b), (c) is dispositive of the proposition that no agency relationship could legally exist between the MFCU as evidenced by CFR §1007.9.

> **§1007.9 Relationship to, and agreement with, the Medicaid agency.**
> (a) The Unit must be separate and distinct from the Medicaid agency.
> (b) **No official of the Medicaid agency will have authority to review the activities of the unit or to review or to overrule the referral of a suspected violation to an** appropriate prosecuting authority.
> (c) The unit will not receive funds pain under this part either from or through the **Medicaid agency.**

The District Court agreed: "...she [Becker] does acknowledge that at the beginning [filing her complaint in August, 2002] she was not correct in her assumptions about who was whom." (T.T. 199:13-19); and,

> **"Plaintiff's confusion about the legal and functioning distinctions between Defendant and the Medicaid Fraud Control Unit have been the primary problem** driving this litigation. Federal law requires the State of Utah to create the Medicaid Fraud Control unit, which was formerly part of the Utah Department of **Public Safety, and is now operated by the Utah Attorney General. The Medicaid Fraud Control unit has never been a part of the Defendant or an agent or designee** of the Defendant, because that is prohibited by Federal law." (December 3, 2005, Ruling on Defendant's Motion to Dismiss).

Moreover, Defense counsel had sternly questioned Dr. Becker on the witness stand about her comprehension of Rule 11 of the Rules of Civic Procedure. He implied that Dr. Becker should have understood that the obvious impossibility of an agency existence in this case tainted her frequent use of the term "agent" or designee in her complaint as arguably frivolous (T.T. 214:15 to 215:12). The district court may have found this argument persuasive.

The District Court appeared to rely on well established contract law for its finding that Medicaid's lack of control over the MFCU precludes agency. Moreover, the District Court also relied on CFR § 1007.9 which cited the separate/distinct nature of the MFCU precluding any "legal connection, agency or identity between Medicaid and the MFCU."

In recognition of this, the District Court judge concluded that Dr. Becker's lengthy and "confused" attempts to create such agent relationship was without merit, "...the primary problem driving this litigation."

In its decision for dismissal, the District Court sustained points already specifically argued by Defendant Medicaid's opening statement at trial, e.g.:

1) THE MFCU has "never been part of the defendant" "...because that is prohibited by federal law."
2) Thus, while the defendant and MFCU had concurrent jurisdiction to some degree, this did not make one an agent, designee or part of the other.
3) Medicaid's providing their findings in regard to Dr. Becker's upcoding to the MFCU did not impose any duty on Defendant because it did not constitute an action on the part of Medicaid until Medicaid notified Dr. Becker of their finding and demand restitution years later at which time they granted her request, thereby meeting their obligation.
4) Therefore, Medicaid did not initiate Dr. Becker's MFCU investigation.
5) Consequently, Dr. Becker failed to prove any Breach of Contract or any damages by DOH-Medicaid.

As to the ramifications engendered by the surprise trial testimony from the State witnesses, admitting Medicaid's own earliest (1998-1000) active involvement implicating Dr. Becker, the District Court apparently found that fact to be of insufficient merit in that collaboration between Medicaid and the MFCU did not constitute an action by defendant and hence did not obligate Medicaid to act before they did three years later, upon a Medicaid letter of demand to Dr. Becker, as condition precedent required by the Utah Medicaid Provider Manual (1998) Section 6-13 and 6-14:

> 6-13 Other Recovery of Payments
> When services for which the Medicaid program provided reimbursement cannot be verified by adequate records as having been furnished, or when a provider unreasonably refuses to provide or grant access to records as described above, either the Provider must promptly refund to the State any payments received by the Provider, or the State may elect to deduct an equal amount from future reimbursements.
>
> 6-14 Administrative Review/Fair Hearing
> A provider may request an agency conference or formal hearing if dissatisfied with any decision made by the Division of Health Care Financing. A formal hearing before the Department of Health may be requested within 30 days of the agency action. The request for the agency conference and/or formal hearing must be in writing and sent to:
> DIVISION OF HEALTH CARE FINANCING
> (emphasis supplied)

The District Court pointed out at trial that there was no documentary evidence given of a written request by Dr. Becker (T.T. 305:22 to 306:8) until in answer to Medicaid's letter demand to her in December 2000.

In addition, the Honorable District Court Judge also corrected Dr. Becker that she was grammatically mistaken in her erroneous interpretation of the contract's punctuation regarding the term 'designee', as she mistakenly claimed it pertained to the MFCU:

(Contract p.2 B-2) "...as the State and its designees, the Fraud Control Unit, or the Secretary of the United States Department of Health and Human Services (HHS) may request" (T.T. 246:1-3).

Furthermore, counsel for Medicaid may have been persuasive to the Court when he stated at trial (T.T. 198:1-3) that "...she [Becker] acknowledges that she understood that we [Medicaid] have no control over MFCU".

Counsel for the Defendant elaborated by further stating at trial that Dr. Becker had been unsuccessful in all her previous legal actions against the MFCU without any recoveries; and that she now attempts to 'bootstrap' her claim against Medicaid into a contract action (T.T. 8:15 to 9:25). He continued in his opening statement by arguing that "any implied terms are expressedly prohibited by federal law and are contrary to public policy" (T.T. 10:11-14). These presentations to the District Court appear to have been persuasively argued. Whether they played any role in the courts ultimate dismissal is of necessity conjectural.

Plaintiff/Appellant now offers the following rebuttal:

POINT I: MEDICAID BY ITS MFCU AGENT INITIATED DR. BECKER'S CODING INVESTIGATION.

The District Court ruled that Defendant Medicaid did not initiate, control, or direct Dr. Becker's investigation by the MFCU (Findings of Fact #6). Dr. Becker consistently alleged that Medicaid did in fact initiate her criminal investigation by their indiscriminate

transfer of all of Utah's provider's medical service codes to the MFCU upon a one-time 'give us all' request 10 years ago (T.T. 35:20 to 36:9).

While the MFCU is legally entitled to billing code information from Medicaid, its contractual Memorandum of Understanding with Medicaid (1987 MOU) clearly states that this exchange must follow upon "written requests" [plural] from the MFCU (T.T. 219:14 to 221:5; 42 CFR § Ch. IV 431.107 (b)(2)).

Medicaid's de facto abdication in 1985 to the MFCU of its mandated post-payment review of Medicaid providers, (CFR § 455.13 et seq., Complaint p.4, Nos. 14-17 and Exhibit F) was the sine qua non basis for initiating the MFCU's investigation of Dr. Becker who was unknown and unreported to the MFCU by any other source.

Most importantly, the MFCU has consistently held itself out to Dr. Becker as an agent of/or as Medicaid per se by their own written statements exhibited to the District Court and well known by the DOH (see Complaint Exhibit C).

Black's Law Dictionary, citing the Agency Restatement 2d, defines:

> *Apparent agent or ostensible agent*. One whom the principal either intentionally or by want of ordinary care, induces third persons to believe to be his agent, though he has not either by expressly or by implication, conferred authority on him. A person who, whether or not authorized, reasonably appears to a third person, because of manifestations of another, to be authorized to act as an agent for such other."

The Honorable District Court judge discounted Dr. Becker's heretofore of necessity much stressed agency connection alleged early in her Complaint as a "...confusion about the legal and functioning distinctions between defendant and the [MFCU]"..., holding that Medicaid did not control or was never a part of the MFCU.

Dr. Becker was not confused. She was justified to interpret the Medicaid Fraud Unit to be the law enforcement agent of the State Medicaid Program. This is especially true in light of the MFCU's multiple written manifestations to her, indicating that they acted on behest and by the authority of Medicaid itself (as preserved in the record).

> Wardley Better Homes v. Cannon 2002 UT 99 (Utah 10/11/2002):
> [38] "[A] principal is affected with constructive knowledge, regardless of his actual knowledge, of all material facts which his agent receives notice or acquires knowledge while acting in the cause of his employment and within the scope of his authority, although the agent does not in fact inform the principal thereof."
> [41] "While vicarious liability is generally limited in tort cases, we have applied the principle of imputation of knowledge to cases lying in tort, contract, securities and property law." [emphasis added]

MFCU prosecutor Kroll testified that the MFCU "...was an agent and designee of the [federal] OIG or Secretary of Health and Human Services..." (T.T. 266:11-21).

Likewise, Medicaid's witness, MR. Gatzemeier, indicated that the MFCU was funded by the federal government (T.T. 32:2-4).

Both statements are false and this apparently confused the MFCU and Mr. Kroll as to their imagined roles. The MFCU was never an agent of or directly funded by the federal government. While the U.S. Department of Health contributed a part of the monies to the state Medicaid program, these contributions enter the Utah General Fund and are supplemented by the State. Both Medicaid and MFCU fall under Utah's Executive Branch which pays/hires/fires them without any control by the U.S. Federal Department of Health (formerly MCFA-now CMS) or its OIG.

Dr. Becker has disputed these serious misconceptions asserted by the defendant, yet they may well have been persuasive to the District Court which states in its

Conclusion of Law Number 4: "Federal law prohibits the [MFCU] from being the agent or designee of the defendant." Dr. Becker has no knowledge of such law and the court has cited none.

The defendant and apparently the District Court relied chiefly on CFR Ch. V § 1007.9 (a)(b)(c) for their proof that "...one is not the agent of the other," (Conclusion of Law Number 10); and therefore Medicaid could not have initiated the MFCU investigation by way of a nonexistent agent.

Dr. Becker alleges that the fact:

§ 1007.9(a) – that the unit must be 'separate and distinct' does not evidence a legal prohibition of a restricted and specified agency relation;

§1007.9(b) – that Medicaid will have 'no authority to overrule or review the prosecutorial activities of the unit' is irrelevant to the case at bar. Dr. Becker never made such a request (T.T. 89:22-24); or

§ 1007.9(c) - that the separate funding of the unit and of Medicaid is little more than a common accounting measure with no relevance to agency or apparent agency.

POINT II: THE MFCU FUNCTIONED IN BEHALF OF THE UTAH MEDICAID PROGRAM IN THE ROLE OF A SPECIAL OR APPARENT AGENT

Medicaid's PIU Director, Steve Gatzemeier, prior to trial testimony, consistently denied that he had any knowledge of or had any part in Dr. Becker's investigation by the MFCU (T.T. 22:4; 39:2-4; 40:2-5; 78:11-14).

Hence, Dr. Becker was compelled to assert a Medicaid-MFCU special agent relationship in order to document her earliest 1999 written request to the MFCU and thereby put Medicaid on constructive notice of her request in order to promptly engage Medicaid in a mandated preliminary examination of the alleged miscoding (See Exhibit D of Complaint; Contract p.2(B)) because Dr. Becker's very early prior requests (1998-1999) to Chief MFCU investigator Wright, MFCU counsel/prosecutor Denis Kroll and Mr. Gatzemeier of Medicaid were only oral and by phone, and may possibly later not have been admitted as evidence.

The obvious reason why neither the MFCU nor Medicaid admitted until under oath at trial that they did request and receive an early 1998-99 coding review of Dr. Becker's medical charts is that they were well aware that such an action would trigger a prompt duty upon Medicaid to write to Dr. Becker requesting repayments (Contract, B-2, CFR § 455;14)- thereby initiating an administrative procedure.

Such a hearing would be concurrent with and independent of the MFCU's investigation. A possible favorable administrative outcome for Dr. Becker was not in the prosecutorial interest of the MFCU.

As to Medicaid, which would recover any repayments (T.T. 98:9-15) plus huge penalties ($2,000 per line), should litigation against Dr. Becker have succeeded, their attitude was well stated by counsel for the defense (T.T. 315:15-16): "...its only sensible to say I'll let somebody else do it until I have to..." and "...she carries a burden to demonstrate any factual discrepancies that we're alleging until we allege them. And we allege them when we say, okay, now overpay" [sic] (T.T. 312:3-6).

Dr. Becker alleges that Medicaid did indeed initiate the criminal investigation via its apparent or actual MFCU agent.

Defense counsel's averment "as a matter of policy, it is we who decide when we are going to initiate requests for overpayments" (T.T. 314:16-18), is disingenuous and ignores the clear mandate of B-2 of the contract, and of 42 CFR ch. IV § 455.14; and § 455.21, among other rules and statutes which did not give Medicaid the option of waiting as a matter of convenience to the detriment of the provider-party to the contract. The MFCU was clearly a collaborating part of the Medicaid program in Dr. Becker's investigation and later litigation.

POINT III: MEDICAID'S 1998-1999 DISCLOSURE TO THE MFCU FINDING DR. BECKER GUILTY OF OVERCHARGING OBLIGATED MEDICAID TO INITIATE A PRELIMINARY INVESTIGATION-ADMINISTRATIVE PROCEDURE;

AND

POINT IV: MEDICAID FAILED TO MEET THE OBLIGATION IN A TIMELY MANNER.

Again, counterpoints III and IV to the District Court's findings are combined here due to their derivative relationship.

The District Court concluded as a matter of law that "7. Providing information to the MFCU did not constitute an agency action that imposed any duty on Defendant under the Provider Agreement."

This conclusion appeared to be based on the Judge's reading of the contract's Section B-2, upon which Dr. Becker partly relied in her breach of contract claim:

B-2: "...Where claimed services cannot be verified by records normally used to substantiate billings, such as patient medical records, any payments revived by PROVIDER for those services will be promptly refunded to the STATE. The PROVIDER will accept the burden of proof to substantiate all services provided to Title XIX/UMAP recipients." [emphasis supplied]

The Honorable District Court Judge was apparently not persuaded that the above-cited paragraph (B-2) sufficed to clearly indicate an obligation for Medicaid to grant a provider a preliminary administrative process/hearing, or even to inform the provider of Medicaid's finding of her wrong upcoding (T.T. 307:24-to-309:14 et seq.; 94:4-13).

In fact, the lower court seemed reluctant to consider those of Dr. Becker's claims based on the contract's binding Medicaid Code of Federal Regulations (CFR), Utah State Acts and DOH rules not specifically cited in the four corners of the contract as controlling or obligating duties.

The four corners of the contract (five pages) obligate both parties to conform inter alia, to Title XIX (approximately 130,000 pages) and thousands more (CFR approximately 3,300 pages), Provider Manual, etc. (T.T. 108:17-20; 105: 1; 105:14-20; 109:10-18).

Where did the judge get the notion that a written request was required? Was it from the Utah Administrative Procedure Act? Where did the judge get the notion that the MFCU was 'separate and distinct' if not from the CFR? Neither term is even named within the four corners of the contract. The Judge did not comment on whether there were

ambiguities in the contract. If there were none-then it is crystal clear that no written notice was required. On the other hand, if there are ambiguities then all ambiguities are to be resolved in favor of the contract's non-drafting party (Dr. Becker).

Therefore, the five pages of the signed agreement merely direct Medicaid and Providers toward defining and comprehensive duties and obligations as elaborated in the CFR, etc.

Nevertheless, from the Honorable Judge's comments during trial it is apparent that he had difficulties accepting the view.

THE COURT: "...are you saying that is a violation of the CFR *or* a violation of the contract?" [emphasis supplied] (T.T. 300:22-24; 91:4-13; 309:12-24).

COUNSEL for Dr. Becker responded: "I am saying that the CFR defines the contract..." (T.T. 300:25-to-301:1).

Even if Dr. Becker would be restricted to prove her claims exclusively from the four corners of the written contract, she should prevail on the language of B-2 of the contract as cited above.

The obligation to 'promptly' refund overpayments if she fails to substantiate her 'burden of proof' clearly implies a speedy time line for this process. Dr. Becker had from the start (1998-1999) self-referred herself to Medicaid (Mr. Gatzemeier) as an accused upcoder.

Counsel for Medicaid in his opening statement averred that: "We will demonstrate that any implied terms, and this is important, that any implied terms are expressedly prohibited by federal law and are contrary to public policy." (T.T. 10:11-14).

However, counsel failed to cite any law to that effect. Or course, Dr. Becker cannot claim to know whether that statement was persuasive to District Court Judge in his decision to dismiss.

In any event, the statement is without merit.

> UCA 63-30-5 cites (Notes to Decisions) well-established law:
> "Implied covenants.
> By its waiver of immunity "as to any contractual obligation, " the state is liable for its breaches of the covenant of good faith and fair dealing implicit in its contracts. Brown v. Weis, 981 P.2d 552 (Utah Ct. App. 1994).

The 'good will' implied in any contract is an important public policy consideration, particularly in contracts made by the state.

Moreover, Defendant Medicaid relied almost exclusively on the CFR and Utah's Administrative Procedure Act terms in the Provider Manual for its defense before the trial court without the Judge ever challenging these citations as outside the four corners of the contract.

Defendant Medicaid, Dr. Becker and the contact terms themselves clearly and uniformly agree that these State and Federal laws, Rules and Acts are integral parts of the contractual Provider Agreement (T.T. 108:17-20; 109:13; 122:13 et seq.: 104:20-to-105:20).

On the other hand, the Honorable Judge of the District Court evidenced repeated reluctance to accept them as defendant's obligations, even in the light of the agreement's specified language:

P.2 Provider Contract:

> PURPOSE
> "Provide services within the scope of PROVIDER'S licensure as authorized under **the laws of the State of Utah, in accordance with provisions of State law, including** State regulations and standards, as amended, implementing Title XIX of the Social Security Act, as amended and State law implementing the Utah medical Assistance Program (UMAP), as amended; this agreement to become effective as **a binding contract between the parties upon acceptance and execution by STATE at STATE's business office at Salt Lake City, Utah."**

And p.2 A-2:

> STATE AGREES TO:
> "Furnish PROVIDER, upon State's acceptance and final execution of this agreement, current copies of relevant provider manuals I effect at the time of execution; and further, to furnish PROVIDER during the period of time this agreement is in effect, copies of relevant updates, information bulletins and other related materials thereto." [emphasis supplied]

Thus it is clearly documented in the agreement contract that both parties are bound by all obligations and benefits contained in "State regulations and standards...implementing Title XIX of the Social Security Act...(UMAP)..."

Moreover, in order to conclude that Medicaid owed Dr. Becker no duty at the time of her early requests the District Court ignored the clear mandate of CFR §455.14:

> Preliminary Investigation:
>
> "If the agency [Medicaid] receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation." [emphasis supplied]

The court below concluded that absent a purely discretionary initiating action by Medicaid, such as informing the provider and demanding repayments, Medicaid has no duty to grant a preliminary investigation under the provider agreement (conclusion of law No. 7; see T.T. 146:3-to-148:7). Such preliminary investigation will always result in a hearing if the investigated Provider contests any miscoding.

Obviously the trial court was not even swayed by Medicaid's PIU Director Gatzemeier's sworn testimony at trial when he replied to the question:

Q. "Is it your belief that nobody has a right to any hearing or to marshall evidence to convince you otherwise until you – your agency actually send them a letter saying give us money back?"

A. "Absolutely not. A provider has and a client has a right to file a hearing at any point in time that they feel they are aggrieved and we have an administrative hearing process to – to listen to that. They don't have to be notified by us that they have a problem. If in fact they feel that they have been unfairly treated or whatever else they can file based on that and we will – we will look at that and determine if in fact there is something we can have a hearing on" (T.T. 147:19-to-148:7). [emphasis supplied]

The District Court had opined at that point that the state's own chief expert witness, PIU Director Gatzemeier's stated beliefs are essentially "irrelevant" (T.T. 146:10-17).

Again, Dr. Becker maintains that her requests were openly denied and only secretly complied with, which was of no benefit to her (Gatzemeier T.T. 172:3-to-173:14).

Had she been informed of the PIU's early indication of upcoding, that information would have been of great value to her, possibly contributing to a settlement out of court.

The District Court's conclusion of law that Medicaid's proactive dissemination to the MFCU of Dr. Becker's incriminating overcharges did not constitute a Medicaid action that imposed a duty on Medicaid is factually and legally unsustainable even recognizing the Honorable District Court's wide discretion and in a light most favorable to its findings and conclusions. See Kunzler v. O'Dell, 855 P.2d 270, 273 (Utah Ct. App. 1983).

POINT V: PLAINTIFF/APPELLANT DID NOT FAIL TO ESTABLISH MEDICAID'S BREACH OF CONTRACT AND DERIVATIVE DAMAGES

Dr. Becker hereby incorporates arguments made in POINTS I through IV for POINT V. Even if any terms of the contract were viewed by the District Court as ambiguous (and the court below has not so indicated), - Dr. Becker reiterates that this contract is undeniable one of "Adhesion", resolving ambiguities in her favor (Complaint p. 10, 38-40).

Counsel for the defense in his concluding trial statement declared: "But the issue is was there a contractual obligation to go any quicker than we did. They [Becker] pointed to nothing" (T.T. 312:25-to-313:2).

This statement goes beyond credulity. The 'obligation to go any quicker than we did' is the gravamen of Dr. Becker's case and was argued by her upon laws and regulations at length and throughout.

Likewise, counsel presented to the court that "...plaintiff has brought other lawsuits based on the activities of the [MFCU]. Today she has been unsuccessful on all of these action" (T.T. 8:15-18).

However, Dr. Becker has brought only one such Federal suit under § 1983 on several constitutional issues. That case is presently on appeal to the 10th Circuit Court and not yet lost, but it is also irrelevant to the case at bar. In fact, the State is the only entity which failed to prevail in every filed suit against Dr. Becker – civil, criminal and eventually the administrative process.

Dr. Becker is well aware that she seeks an appeal from the 5th District Court's decision and not from what counsel for DOH-Medicaid averred. Nevertheless, she cites these misleading statements to the court as possible influencing contributions to the Honorable Judge's eventual conclusions.

The District Court's very minimal exposition of its reasons for dismissal was partly engendered by its busy schedule: "I do not have the time available for the drafting a scholarly decision so this summary explanation will have to suffice." (Judge Beacham's ruling, December 3, 2005); and "...having done my best to skim through the documents that have been put into evidence and some of the statutes...(T.T. 316:23-to-317) [emphasis added].

Dr. Becker alleges on appeal that the lower tribunal's findings of fact and conclusions of law are insufficiently detailed to establish their foundation. See Woodward v. Fazzio, 823 P.2d 474 (Utah Ct. App. 1991), Campbell v. Campell, 896 P.2d 635, 638-39 (Utah Ct. App. 1995).

Once more, Dr. Becker is of necessity and uncomfortably relegated to conjectures as to the several facts and laws, which might have led the 5th District Court to its findings and conclusions.

Plaintiff/Appellant Dr. Becker is not able with all diligence to find any clearly stated law by the District Court upon which she could marshall a reasoned answer other than she has by citing laws and regulations, etc., which clearly show that Medicaid breached the contract and by its action and inaction was the direct or proximate cause of very substantial damages to her which have not been argued because of the dismissal of her case (T.T. &:18-21).

CONCLUSION

A contract of adhesions existed between DOH-Medicaid and Dr. Becker (not controverted by the parties).

The contractual 'Provider Agreement' additionally bound both parties by specific reference to numerous Federal and State laws, rules and regulations; provided benefits and established mutual obligations (not controverted by the parties).

Dr. Becker filed a suit in breach of contract, which was dismissed by the District Court. She next filed a Motion for New Trial in which she pointed out new surprise evidence revealed at trial and material reversible errors in the District Court's decision in order to move the lower tribunal to reconsider.

Dr. Becker thereby preserved those issues as timely raised. See State v. Rudolph, 970 P.2d 1221, 1225-26, 1227 (Utah 1998); State v. Preece, 971 P.2d 1, 6 (Utah Ct. App. 1998). The motion was denied.

In reliance on her arguments as briefed above, Dr. Becker alleges that the Honorable 5th District Court's finding of fact and conclusions of law are insufficient to support its decision even when viewed in a light most favorable to the trial court. See Johnson v. Higley, 977 P.2d 1209, 1217 (Utah Ct. App. 1993). They evidence substantial reversible error, prejudicial to Dr. Becker's case. The District Court's more careful consideration of the surprise testimony at trial should have caused the outcome to be in Dr. Becker's favor.

Dr. Becker is not vague in her appeal in showing that the trial court exceeded its measure of discretion (Kunzler v. O'Dell) by incorrectly interpreting and applying the relevant CFR and other Federal and State laws and binding rules in contradiction to their plain language and against the clear evidence preserved in the record, see State ex rel J.N., 960 P.2d 403, 407 (Utah Ct. App. 1998).

The damages prayed for remain those of the Complaint, pp. 11-12:

PRAYER FOR RELIEF

WHEREFORE: Plaintiff prays for relief as follows:

1. General Damages: To restore the Plaintiff to her former position, -prior to the loss of business and litigation expenses foreseeably and directly caused by the material loss

of a benefit of the contract to which Plaintiff had every reasonable expectancy, and upon which Plaintiff relied.

2. Special Damages: The Defendant's failure to mitigate the damage by performing its covenanted duty to furnish the Plaintiff with repeatedly requested pre-litigation administrative review, consequentially led to the material breach of a contractual duty causing substantial damage to the Plaintiff's reputation, income and entailed predictable physical/mental harm upon her person which was readily foreseeable by the defendant in this case.
3. Such other relief as this Court may deem appropriate.

Dr. Becker will furnish an expert witness testifying to the amount of damages. Plaintiff/Appellant prays that the Honorable Court of Appeals remand this case for trial on the contested issues.

ADDENDUM:

SUPPORTING LAWS AND REGULATIONS:

A. **Medicaid Agreement B-2**

Administrative Procedure Act Excerpts

Provider Manual

B. Code of Federal Regulations (CFR)

C. **Rule R410-14-1, -2, -3**

D. CFR § 1007.19(e) and (e)(2)

E. **Contract (Provider Agreement)**

F. Sec. 5 Utah Medicaid Provider Manual

G. **Ruling on Defendants Motion to Dismiss, December 5, 2005**

H. Findings of Facts, Conclusion of Law and order of Dismissal February 3, 2006

I. **Denial of Plaintiff's Motion (for new trial April 26, 2006)**

J. Becker letter to A.AG Kroll

K. **Draft Settlement, Kroll-to-Becker**

L. Certificate of Service

Plaintiff pro se, Taj Becker, M.D.,

Dated this 13th day of September, 2006

Taj Becker, M.D., Plaintiff Pro Se

Medicaid Contract Agreement B-2:

"...Where claimed services cannot be verified by records normally used to substantiate billings, such as patient medical records, any payments received by the PROVIDER for those services will be promptly refunded to the STATE. The Provider will accept the burden of proof to substantiate all services provided to Title XIX/UMAP recipients."

Administrative Procedures Act 63-46-b1(4)(a)

"(3) This chapter does not affect any legal remedies otherwise available to:

(a) compel an agency to take action; or

(b) challenge an agency's rule.

(4) This chapter does not preclude an agency, prior to the beginning of an adjudicative proceeding, or the presiding officer during an adjudicative proceeding from:

(a) requesting or ordering conferences with parties and interested persons to:

(i) encourage settlement;

(ii) clarify the issues;

(iii) simplify the evidence;

(iv) facilitate discovery; or

(v) expedite the proceedings; or"

63-46b-3. Commencement of adjudicative proceedings.

(1) ...all adjudicative proceedings shall be commenced by either:

(a) a notice of agency action, if proceedings are commenced by the agency; or

(b) a request for agency action, if proceedings are commenced by persons other than the agency.

1998 Provider Manual

§ 5.210 Administrative Hearings

State and Federal laws provide an opportunity for an administrative hearing to any person aggrieved of an action taken by the Department of Health (DOH), Division of Health Care Financing (DHCF)

A

code of federal regulations

Public Health

42

PART 430 TO END

Revised as of October 1, 1999

CONTAINING A CODIFICATION OF DOCUMENTS OF GENERAL APPLICABILITY AND FUTURE EFFECT AS OF OCTOBER 1, 1999

With Ancillaries

Published by the Office of the Federal Register National Archives and Records Administration as a Special Edition of the Federal Register

Subpart A—Medicaid Agency Fraud Detection and Investigation Program

§ 455.12 State plan requirement.

A State plan must meet the requirements of §§ 455.13 through 455.23.

§ 455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have—

(a) Methods and criteria for identifying suspected fraud cases;

(b) Methods for investigating these cases that—

(1) Do not infringe on the legal rights of persons involved; and

(2) Afford due process of law; and

(c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3755, Jan. 27, 1983]

§ 455.14 Preliminary investigation.

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

§ 455.16 Resolution of full investigation.

A full investigation must continue until—

(a) Appropriate legal action is initiated;

(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or

(c) The matter is resolved between the agency and the provider or recipient. This resolution may include but is not limited to—

(1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;

(2) Suspending or terminating the provider from participation in the Medicaid program;

(3) Seeking recovery of payments made to the provider; or

(4) Imposing other sanctions provided under the State plan.

§ 455.21 Cooperation with State Medicaid fraud control units.

In a State with a Medicaid fraud control unit established and certified under subpart C of this part,

(a) The agency must—

(3) On referral from the unit, initiate any available administrative or judicial action to recover improper payments to a provider.

Rule R410-14. Administrative Hearing Procedures.

As in effect on June 1, 2001

UT Admin Code R410-14 Administrative Hearing Procedures.

R410-14-1. Introduction and Authority.

(1) Division policy is to resolve disputes at the lowest level. This rule is not meant to foreclose the Division's preference for informal resolutions through open discussion and negotiation between the Division and aggrieved persons

R410-14-2. Definitions.

(1) The definitions in R414-1 and Section 63-46b-2 apply to this rule.

(2) In addition, as used in this rule

(a) "Action" means a denial, termination, suspension, or reduction of Medicaid or UMAP covered services regarding an applicant or a recipient; or a reduction or denial of reimbursement for services

(b) "Aggrieved Person" means any applicant, recipient, or provider adversely affected by any action or inaction of DHCF

R410-14-3. Administrative Hearing Procedures.

(1) All Title XIX (Medicaid) or Utah Medical Assistance Program (UMAP) applicants, recipients, or providers aggrieved by any action or inaction of the Department of Health (DOH), Division of Health Care Financing (DHCF), may file a written request for agency action pursuant to 63-46b-3 and in accordance with this rule. All proceedings before DHCF, except as otherwise set forth, shall be conducted as a formal hearing. DHCF conducts hearings on many subjects including the following:

Note: § 1007.19(e) and (e)(2)

(ii) All establishment costs will be deemed made in the first quarter of certification.

(e) *Costs not subject to FFP.* FFP is not available under this part for expenditures attributable to—

(1) The investigation of cases involving program abuse or other failures to comply with applicable laws and regulations, if these cases do not involve substantial allegations or other indications of fraud;

(2) Efforts to identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with recipients of whether services billed by providers were actually received;

(3) The routine notification of providers that fraudulent claims may be punished under Federal or State law;

(4) The performance by a person other than a full-time employee of the unit of any management function for the unit, any audit or investigation, any professional legal function, or any criminal, civil or administrative prosecution of suspected providers;

(5) The investigation or prosecution of cases of suspected recipient fraud not involving suspected conspiracy with a provider; or

(6) Any payment, direct or indirect, from the unit to the Medicaid agency, other than payments for the salaries of employees on detail to the unit.

§ 1007.21 Other applicable HHS regulations.

Except as otherwise provided in this part, the following regulations from 45 CFR subtitle A apply to grants under this part:

Part 16, subpart C—Department Grant Appeals Process—Special Provisions Applicable To Reconsideration of Disallowances [Note that this applies only to disallowance determinations and not to any other determinations, e.g., over certification or recertification];

Part 74—Administration of Grants;

Part 75—Informal Grant Appeals Procedures;

Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services, Effectuation of title VI of the Civil Rights Act of 1964;

Part 81—Practice and Procedure for Hearings Under 45 CFR part 80;

Part 84—Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance;

Part 91—Nondiscrimination on the Basis of Age in HHS Programs or Activities Receiving Federal Financial Assistance.

PART 1008—ADVISORY OPINIONS BY THE OIG

Subpart A—General Provisions

Sec.

Subpart B—Preliminary Obligations and Responsibilities of the Requesting Party

Subpart C—Advisory Opinion Fees

Subpart D—Submission of a Formal Request for an Advisory Opinion

Subpart E—Obligations and Responsibilities of the OIG

Subpart F—Scope and Effect of OIG Advisory Opinions

D

PROVIDER AGREEMENTS

A Provider Agreement regarding participation in both the Title XIX (Medicaid) and the Utah Medical Assistance Program (UMAP) is attached.

Please sign and return the agreement promptly to assure our continued compliance with federal and state requirements for uniform provider agreements. MEDICAID CANNOT ACCEPT ANY AGREEMENT THAT HAS BEEN ALTERED OR CHANGED IN ANY WAY.

Please return the signed agreement and any application materials to:

Provider Enrollment
Division of Health Care Financing
Bureau of Medicaid Claims Processing
PO Box 16520
Salt Lake City, Ut 84116-0520

JOINT UTAH MEDICAID/UTAH MEDICAL ASSISTANCE PROGRAM (UMAP) PROVIDER APPLICATION AND AGREEMENT

WHEREAS, by separate application containing relevant licensure and supporting information thereof, a request has been made and is now on file by the within named Provider for qualification and acceptance of Provider as a Medicaid/UMAP Provider;

NOW, THEREFORE:

This agreement is entered by and between the Utah Department of Health, Division of Health Care Financing, hereinafter referred to as the STATE, and the following individual, partnership or corporation, hereinafter referred to as the PROVIDER.

PURPOSE

Provide services within the scope of PROVIDER's licensure as authorized under the laws of the State of Utah, in accordance with provisions of State law, including State regulations and standards, as amended, implementing Title XIX of the Social Security Act, as amended, and State law implementing the Utah Medical Assistance Program (UMAP), as amended; this agreement to become effective as a binding contract between the parties upon acceptance and execution by STATE at STATE's business office at Salt Lake City, Utah.

A. STATE AGREES TO:

1. Pay PROVIDER for services furnished to Medicaid/UMAP recipients in accordance with the fee schedule in effect at the time the services are rendered as established under State law, regulations, methods and procedures; and, as appropriate, in accordance with the Social Security Act and federal implementing regulations and directives; with, as used herein, the term "Billed Charges" meaning the usual and customary charges to the general public for such services.

2. Furnish PROVIDER, upon State's acceptance and final execution of this agreement, current copies of relevant provider manuals in effect at the time of execution; and further, to furnish PROVIDER during the period of time this agreement is in effect, copies of relevant updates, information bulletins and other related materials thereto.

B. PROVIDER AGREES TO:

1. Provide services to eligible Title XIX/UMAP recipients regardless of sex, race, creed, color, national origin, age, or handicap.

2. Maintain all records for a minimum of five (5) years (or until all audit questions have been resolved) that are necessary to disclose fully the extent of all services related to billed charges provided to individuals under Utah's Title XIX/UMAP programs and furnish all required information regarding any payments claimed for providing such services as the State and its designees, the Fraud Control Unit,

or the Secretary of the United States Department of Health and Human Services (HHS) may request. Where claimed services cannot be verified by records normally used to substantiate billings, such as patient medical records, any payments received by the PROVIDER for those services will be promptly refunded to the STATE. The PROVIDER will accept the burden of proof to substantiate all services provided to Title XIX/UMAP recipients.

3. Submit within thirty-five (35) days of the date of request by the Secretary of HHS or the Medicaid/UMAP agency, full and complete information about:

   (a) The ownership of any subcontractor with whom the PROVIDER has had business transactions totaling more than $25,000 during the 12 month period ending on the date of request; and,

   (b) Any significant business transactions between the PROVIDER and any wholly owned supplier or between the PROVIDER and any subcontractor, during the 5-year period ending on the date of request.

4. Disclose to the STATE any person who has ownership or control interest in the PROVIDER, or is an agent or managing employee of the PROVIDER that has been convicted of a criminal offense related to that persons involvement in any program under Medicare, Medicaid, UMAP, or the Title XX services program since the inception of those programs.

5. Act as an independent contractor, and as such, shall have no authorization, express or implied, to bind the State of Utah or the STATE agency to any agreement, settlement, liability or understanding whatsoever, nor to perform any acts as agent for the State of Utah, except as herein expressly set forth in this agreement.

6. Accept payment by the STATE as payment in full for Medicaid/UMAP covered services.

7. Agree to be bound by all provisions of federal and or state law implementing Title XIX of the Social Security Act, and/or UMAP, as amended, including all state regulations and standards, as amended from time to time, as presently in force and effect at the time of final execution of this agreement, and all amendments thereto hereinafter passed and approved, including all relevant provider manuals, updates, information bulletins and other related materials thereto, including but not limited to CPT code changes and/or other uniform coding systems now in effect or hereinafter authorized by the STATE.

8. And, by these presents, acknowledges that upon STATE's acceptance and final execution of this agreement, that STATE will assign and forward to PROVIDER a specific Medicaid/UMAP Provider Number, and that PROVIDER agrees to file and process all claims for services rendered under this agreement utilizing said specific Medicaid/UMAP Provider Number only.

9. And, by these presents, acknowledges that upon STATE's acceptance and final execution of this agreement, and the assignment and forwarding of the specific Medicaid/UMAP Provider Number as set forth in Section B.8, immediately above, that:

   (a) As concerns a non-previously participating Medicaid/UMAP provider, as determined by the revision date of the present agreement, STATE will forward to such non-previously participating provider a current copy of all relevant provider manuals, updates, information bulletins and other related materials thereto, in effect at the time of STATE's final execution; and further, that said non-previously participating provider, upon receipt of said Medicaid/UMAP Provider Number, provider manuals, and other related materials, agrees to notify STATE in writing immediately should said aforementioned manuals and/or related materials be incomplete and/or absent.

   (b) As concerns a presently participating Medicaid/UMAP provider, as determined by the revision date of the present agreement and upon receipt of said Section B.8 notification and forwarding of said Medicaid/UMAP Provider Number, such presently participating provider agrees to notify STATE in writing immediately as to the incompleteness and/or absence, if any, of relevant provider manual materials, and/or other related materials, then in the possession of said presently participating provider.

C. <u>BOTH STATE AND PROVIDER AGREE</u>:

1. That STATE under the terms of this agreement is acting solely in the capacity as a source of reimbursement and funding under the auspices of federal and state medical assistance programs.

   Therefore STATE is in no way guaranteeing the level of and/or quality of services rendered by PROVIDER under the terms of this application and agreement.

   That as such PROVIDER agrees to indemnify and hold harmless the STATE and its officers, agents, and employees from and against any and all loss, damages, injury, liability and claims therefore, including claims for personal injury or death, and damages to personal property which the STATE is found legally obligated to pay solely because of acts or omissions of PROVIDER or any employee of PROVIDER and/or party under contract with PROVIDER, arising under the terms of this agreement.

   <u>Further</u>, both parties hereto agree to bear their own reasonable attorney's fees and/or litigation expenses resultant in any such action or actions brought in relation thereto.

2. That both parties will be bound by and comply with federal and state law

regarding confidentiality of records and recipient rights of privacy regarding the Title XIX/UMAP programs.

3. That this agreement shall be effective for a period of one (1) year with automatic one (1) year extensions thereafter, unless sooner terminated, with or without cause, by either party serving not less than thirty (30) days written notice on the other party of intent to terminate. In the event of termination, payments shall be made for services rendered up to and including the date of termination.

4. That this agreement replaces any and all previous agreements currently in force, which are hereby terminated upon final execution thereof.

I hereby certify that I have read and will be bound by the terms of this agreement and the herein above referenced and incorporated manuals, updates, bulletins and related materials, and all amendments thereto passed and approved during the ~~period of time this agreement~~ is in effect.

TAJ N. BEELER M

Type or Print Provider Name

Signature of Provider

RECEIVED
SEP 29 1994
PROVIDER FILE

Date: 9/28/94

The above and foregoing is hereby accepted and approved; and the following Medicaid/UMAP Provider Number is assigned to the aforementioned provider:

5709045330002

Medicaid/UMAP Provider Number

Utah State Department of Health,
Division Of Health Care Financing

TASK COMPLETED
OCT 05 1994
PROVIDER FILE

By: _____

Type ~~or Print Title Of Authorized~~ Party.

Joan M Gallegos

Signature of Authorized Party

Date: OCT 05 1994

*****

Revision Date: 02/05/88

SECTION 5
PROVIDER COMPLIANCE and HEARING RIGHTS

SECTION 5.000
PROVIDER COMPLIANCE

CONTENTS

5.100 General Information

5.110 Provider Agreement

A. Each Provider must execute a Provider agreement before he/she is authorized to furnish Medicaid services. For information concerning the current provider agreement, please contact the Provider File Coordinator at (801) 538-6473 or write to us at:

Bureau of Medical Payments
P.O. Box 16580
Salt Lake City, Utah 84116-0580

B. Upon the State's acceptance and final execution of the provider agreement, the State will forward to each provider a unique provider number and a current copy of the Medicaid Provider Manual. In addition, each provider will periodically receive Medicaid Information Bulletins and related materials from the State.

C. The provider must process all claims for services using his/her unique provider number only. The provider must also abide by the provisions of Title XIX of the Social Security Act, as amended, and any relevant State and Federal law, including rules and regulations, this Provider Manual, Medicaid Information Bulletins, and related materials, including, but not limited to, HCPCS and/or CPT-4 codes and any other uniform coding systems authorized by the State.

5.120 Billing Practices

A. The provider may bill only for services that are medically/clinically indicated and necessary.

B. The provider must use Medicaid forms to bill for services billed to Medicaid (see Section 3.000).

C. The provider's charge shall not exceed the usual and customary rates billed to the general public (including individual patient accounts or third-party payer accounts).

D. Except as may be permitted in Section 2, a provider shall not bill any Medicaid recipient for any covered Medicaid services. Providers must accept the Medicaid payment as payment in full. (If a provider receives a third party payment and does not bill Medicaid for the balance because he/she anticipates the Medicaid payment to be zero, this shall be interpreted as payment in full, and the provider shall not bill the recipient.)

E. In certain circumstances, a provider may bill a recipient for non-covered services. However, the recipient must be advised prior to receiving a non-covered service that Medicaid will not pay for the service and the recipient will be personally responsible for the payment. In addition, prior to receiving a non-covered service, there must be an agreement in writing between the provider and the recipient regarding the service and the amount to be paid by the recipient. Without written agreement, the provider may not bill the recipient, even if the provider chooses not to bill Medicaid. Further, the recipient's ID card may not be held by the provider as guarantee of payment by the recipient, nor may any other restrictions be placed upon the recipient.

5.130 Record Keeping and Disclosure

A. The provider must maintain for a minimum of five (5) years, all records necessary to document and disclose fully the extent of all services provided to Medicaid recipients which were billed, charged or reported to the State under Medicaid.

B. The provider must promptly disclose or furnish, upon request, all information regarding any payment claimed for providing Medicaid services and any other information or records necessary to ascertain, disclose, or substantiate all actual income received or expenses incurred in providing Medicaid services to recipients, or in providing services of the same nature during the same period as Medicaid services, as the State and its designees, the Fraud Control Unit, or the Secretary of the United States Department of Health and Human Services may request.

C. The provider must allow State and Federal auditors and program reviewers to have access to its records, including all financial records for audit review and inspection, on request.

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1. To allow for reasonable inspection and audit of financial or recipient records for non-Title XIX recipients to the extent necessary to verity usual and customary expenses and charges.

2. Request for access to or inspection of documents and records must be promptly and reasonably complied with, and free access to a provider's records and facility at reasonable times and places must be granted to the agents of the State. Providers must not obstruct any audit or investigation including the relevant questioning of employees of the provider.

3. Where services, for which the Medicaid Program provided reimbursement, cannot be verified by adequate records as having been furnished, or where a provider unreasonably refuses to provide or grant access to records as described above, any payments received by the provider for such undocumented services will be promptly refunded to the State, or the State may elect to deduct an equal amount from future reimbursements.

4. Repeated refusal to provide or grant access to the records as described above will result in the termination of the existing Medicaid Provider Agreement.

D. The provider must promptly refund to the State any payments received for claimed services which cannot be verified by records normally used to substantiate billing, such as patient medical records. If such payments are not promptly refunded, the State may elect to deduct them from future reimbursement. The provider shall accept the burden of proof to substantiate all services provided to Medicaid recipients.

5.200 Hearings

.210 Administrative Hearings

State and Federal laws provide an opportunity for an administrative hearing to any person aggrieved of an action taken by the Department of Health (DOH), Division of Health Care Financing (DHCF).

5.220 Hearing Requests

A. A request for an administrative hearing must be submitted within thirty (30) days from the the date written notice of an intended action is mailed by DHCF. A request for a hearing must be in writing and should explain the reasons for which the hearing is requested. It should be forwarded, as instructed in the notice, to the agency which sent to the provider the notice of the action DHCF intends to take. Failure to submit a timely request for a hearing will constitute a waiver of the provider's hearing rights.

B. Each request for a hearing must include:

1. The legal and factual issues the aggrieved person wants to discuss;

2. The specific acts or omissions of DHCF, including all pertinent dates, names, etc., which give rise to the issue(s) the aggrieved person wants to contest;

3. The relief the aggrieved person wants to obtain through a hearing;

4. The laws, rules or regulations relied upon by the aggrieved person to support his/her position as to the issues and relief sought to be considered.

C. Copies of current administrative hearing procedures may be reviewed or obtained at the Division of Health Care Financing.

IN THE FIFTH DISTRICT COURT FOR
WASHINGTON COUNTY, STATE OF UTAH

TAJ BECKER, M.D., Plaintiff, vs. UTAH DEPARTMENT OF HEALTH, et al., Defendants.	RULING ON DEFENDANT'S MOTION TO DISMISS Civil No. 020501574 Judge G. Rand Beacham

This matter came before me for trial on September 28, 2005. The parties were present and represented by their respective counsel of record. Prior to the trial, the parties entered several pre-trial stipulations regarding the evidence and the issues.

At the trial, counsel made their opening statements, and Plaintiff called three witnesses and introduced several documents into evidence. Plaintiff rested, and Defendant moved to dismiss. Counsel made their arguments, and I took the matter under advisement.

I have now reviewed the testimony and exhibits, have considered the parties' arguments, and have reviewed the law governing the issues presented by Plaintiff's claims and Defendant's motion to dismiss. I have decided to grant the motion. I do not have time available for drafting a scholarly decision, so this summary explanation will have to suffice.

1. The Provider Agreement (Exhibit 1) does evidence a contract between Plaintiff and Defendant. The Medicaid Fraud Control Unit is not a party to that contract.

2. Plaintiff's confusion about the legal and functioning distinctions between Defendant and the Medicaid Fraud Control Unit has been the primary problem driving this litigation. Federal

law requires the State of Utah to create the Medicaid Fraud Control Unit, which was formerly part of the Utah Department of Public Safety, and is now operated by the Utah Attorney General. The Medicaid Fraud Control Unit has never been part of the Defendant or an agent or designee of the Defendant, because that is prohibited by federal law. The Defendant's provision of information to the Medicaid Fraud Control Unit, pursuant to the Defendant's legal obligation to provide such information upon the request of the Medicaid Fraud Control Unit, did not alter the Provider Agreement or create a legal connection, agency or identity between the Defendant and the Medicaid Fraud Control Unit.

3. To a degree, the Medicaid Fraud Control Unit and the Defendant have concurrent jurisdiction to investigate allegations of Medicaid fraud by health care providers like Plaintiff. This fact does not make one the agent of the other. The investigation of Plaintiff by the Medicaid Fraud Control Unit was not initiated by the Defendant, controlled by the Defendant, or directed by the Defendant. That investigation did not implicate any contractual obligation of the Defendant to Plaintiff, nor did it trigger any duty for the Defendant either (a) to hold an administrative hearing with Plaintiff regarding the Medicaid Fraud Control Unit's investigation or (b) to conduct its own duplicative and concurrent investigation.

4. When the Defendant did undertake an investigation of Plaintiff, the Defendant met its legal duties to provide Plaintiff notice and an opportunity to be heard.

5. Considering the evidence in the light most favorable to Plaintiff, it is clear to me that Plaintiff has failed to prove any breach of contract by the Defendant or any damages caused to Plaintiff by the Defendant.

Accordingly, the motion to dismiss is granted and Plaintiff's complaint is dismissed on the merits. Defendant's counsel shall submit findings of facts and conclusions of law, together with an appropriate judgment of dismissal.

Dated this 30 day of December, 2005.

G. RAND BEACHAM, JUDGE

CERTIFICATE OF MAILING OR HAND DELIVERY

I hereby certify that on this 05 day of Dec, 2005, I provided true and correct copies of the foregoing RULING to each of the attorneys/parties named below by placing a copy in such attorney's file in the Clerk's Office at the Fifth District Courthouse in St. George, Utah and/or by placing a copy in the United States Mail, first-class postage prepaid, and addressed as follows:

Michael N. Martinez
Attorney at Law
Attorney for Plaintiff
4479 Gordon Lane, Suite 101
Salt Lake City, Utah 84107

Lyle Odendahl
Assistant Utah Attorney General
Attorney for Defendant
P.O. Box 141000
Salt Lake City, Utah 84114-1000

DEPUTY CLERK OF COURT

Lyle Odendahl (#4103)
Assistant Utah Attorney General
Mark L. Shurtleff (#4666)
Utah Attorney General
Attorneys for Defendants
PO BOX 141000
Salt Lake City, Utah 84114-1000
Telephone: (801) 538-6878

IN THE FIFTH DISTRICT COURT FOR
WASHINGTON COUNTY, STATE OF UTAH

TAJ BECKER, M.D., Plaintiff, vs. UTAH DEPARTMENT OF HEALTH Defendant.	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER OF DISMISSAL** Civil No. 020501574 Judge G. Rand Beacham

This matter was tried before the court on September 28, 2005 The parties were present and represented by counsel. Prior to the trial, the parties entered several pre-trial stipulations regarding the evidence and the issues.

At the trial, counsel made their opening statements, and Plaintiff called three witnesses and introduced several documents into evidence. Plaintiff rested, and Defendant moved to dismiss. Counsel argued the motion to dismiss at that time.

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The court, having reviewed the testimony and exhibits, considered the parties' arguments, and reviewed the law governing the issues presented by Plaintiff's claims and Defendant's motion to dismiss, and being fully advised in this matter, enters the following:

I. FINDINGS OF FACT

1. Plaintiff signed a document entitled "Joint Utah Medicaid/Utah Medical Assistance Program (UMAP) Provider Application and Agreement" (Provider Agreement), which Defendant accepted to enroll Plaintiff as a provider for Utah Medicaid and the Utah Medical Assistance Program.

2. The Utah Medicaid Fraud Control Unit is not a signatory to the Provider Agreement.

3. The Utah Medicaid Fraud Control Unit investigated Plaintiff for alleged over billing.

4. The Utah Medicaid Fraud Control Unit obtained data from Defendant pursuant to Defendant's legal obligations under federal law, which the Utah Medicaid Fraud Control Unit used to identify Plaintiff for investigation.

5. During the Utah Medicaid Fraud Control Unit's investigation Plaintiff requested that the Utah Medicaid Fraud Control Unit to request that Defendant review the Utah Medicaid Fraud Control Unit's initial determinations. Defendant reported to the Utah Medicaid Fraud Control Unit that there was possible fraud.

6. The Utah Medicaid Fraud Control Unit's investigation of Plaintiff was not

initiated by Defendant, controlled by Defendant, or directed by Defendant.

7. The Medicaid Fraud Control Unit brought and then dismissed of a civil complaint and subsequently brought and then dismissed of a criminal complaint a criminal action against Plaintiff. Thereafter, the Utah Medicaid Fraud Control Unit referred the alleged over billing to Defendant.

8. After review of the referral from the Utah Medicaid Fraud Control Unit, Defendant demanded that Plaintiff repay alleged overpayments.

9. Plaintiff requested that Defendant conduct an administrative action to allow Plaintiff to contest the alleged overpayments.

10. Pursuant to Plaintiff's request, Defendant conducted an administrative proceeding at which Plaintiff contested the alleged overpayments.

11. Defendant determined pursuant to the administrative proceeding that Plaintiff owed no reimbursement to Defendant because of the alleged overpayments.

II. CONCLUSIONS OF LAW

1. The Provider Agreement established a contractual relationship between Plaintiff and Defendant.

2. The Medicaid Fraud Control Unit is not a party to the Provider Agreement.

3. The Medicaid Fraud Control Unit has never been an agent of, a designee of, or a part of the Defendant.

4. Federal law prohibits the Medicaid Fraud Control Unit from being the agent or designee of the Defendant.

5. Defendant was obligated by federal law to provide data to the Medicaid Fraud Control Unit to assist the Medicaid Fraud Control Unit in conducting the Unit's independent investigation.

6 Providing information to the Medicaid Fraud Control Unit and reviewing its initial determinations did not alter the Provider Agreement or create a legal connection, agency, or identity between Defendant and the Medicaid Fraud Control Unit.

7. Providing information to the Medicaid Fraud Control Unit and reviewing its initial determinations did not constitute an agency action that imposed any duty on Defendant under the Provider Agreement.

8. The Utah Medicaid Fraud Control Unit's investigation of Plaintiff did not trigger or create any duty, under the contract or otherwise, for Defendant to either (a) hold an administrative hearing regarding the Utah Medicaid Fraud Control Unit's actions, or (b) to conduct its own duplicative and concurrent investigation.

9. The Utah Medicaid Fraud Control Unit's investigation of Plaintiff did not implicate, give rise to, or trigger a contractual obligation by Defendant to Plaintiff.

10. Defendant and the Medicaid Fraud Control Unit have concurrent jurisdiction to investigate allegations of Medicaid fraud, however one is not the agent of the other.

11. Defendant met all its legal and contractual duties to provide Defendant due process, including notice and an opportunity to be heard.

12. After reviewing the evidence in the light most favorable to Plaintiff, this court rules that Plaintiff has failed to prove any breach of contract by Defendant or any damages caused to Plaintiff by Defendant.

WHEREFORE, the court orders that Defendant's motion to dismiss is granted and Plaintiff's complaint is dismissed with prejudice on the merits.

Dated this 3rd day of Feb. 2006.

G. Rand Beacham

G. Rand Beacham, Judge

Approved as to form:

Michael N. Martinez

Michael N. Martinez
Attorney for Plaintiff

IN THE FIFTH JUDICIAL DISTRICT COURT IN AND FOR
WASHINGTON COUNTY STATE OF UTAH
REQUEST TO SUBMIT FORM AND/OR ORDER

FILED
2006 APR 27 PM 5:0

TO: ____ Judge James L Shumate
X Judge G. Rand Beacham
____ Judge Eric A. Ludlow

Re: Case No. 020501574
Plaintiff: Becker
v
Defendant: Utah Dept. of Health

On the 12 day of April, 2006, Request to Submit was filed by:
____attorney for Plaintiff
____attorney for Defendant
X other/prose

The following are submitted for decision:

____Pla's ____Def's Motion for Summary Judgment

____Pla's ____Def's Motion for Judgment on Pleadings

____Pla's ____Def's Motion to ____Dismiss ____Continue ____Compel

____Pla's ____Def's Objection to ____

X Pla's ____Def's Other Motion for New Trial

COURTS RULING:

____Set Hearing Approximate Length____

Other: Denied. See 12-3-05 Ruling and 2-6-06 Findings, Conclusions and Order of Dismissal.

Dated this 26 day of April, 2006.

G Rand Beacham
District Court Judge

rec 5 2 06
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TAJ N. BECKER, M.D.
Neurology
Diplomate, American Board of Psychiatry and Neurology
630 South 400 East, Suite # 102
St. George, UT 84770
phone (801) 688-7800 / fax (801) 688-7801

7/7/99

Mr. J. Denis Kroll
Medicaid Fraud Control Unit
State of Utah
5272 S. College Dr #200
Murray, UT 84123-2611

Dear Mr. Kroll:

This is to inform you that I have decided NOT to settle the legal action initiated against me by the State of Utah arising from the Medicaid Fraud Control Unit's criminal investigation of my medical practice upon careful review of your latest proposal dated 6/24/99

I am fully aware of the loss of time and the many tens of thousands of dollar expenses I will incur if you choose to litigate. Nevertheless, the ramifications of the MFCU's false accusations against me are of such serious nature that it would very likely irreparably impair my continuing the practice of medicine if left unchallenged.

If you will not dismiss this action, or refer your findings back to the Utah Health Care Finance Administration for evaluation and non-criminal resolution between that Agency and myself, I have no reasonable alternative but to await your filing of charges before the proper court where I am confident to have a fair hearing of the matter in controversy.

Sincerely,

Taj N. Becker, M.D

Sent, certified mail with return receipt requested 7-7-99.

J

nc 4.7.99.

J. DENIS KROLL - 1858
Assistant Attorney General
JAN GRAHAM - 1231
Attorney General
Attorneys for State of Utan
5272 College Drive, #200
Murray, Utah 84123
Telephone: (801)284-6253

DRAFT

IN THE THIRD DISTRICT COURT, STATE OF UTAH

SALT LAKE COUNTY, MURRAY DEPARTMENT

STATE OF UTAH, Plaintiff, vs. TAJ N. BECKER, M.D., Medicaid Provider No. 570904533002, Defendant.	:	STIPULATION OF PARTIES: SETTLEMENT AGREEMENT, RELEASE OF CLAIMS, CONSENT TO JUDGMENT Civil No. _____

RECITALS

1. The Parties. The parties to this Settlement Agreement are State of Utah, Medicaid Fraud Unit, ("Medicaid"), and Taj N. Becker, M.D., ("Becker"), and make their general appearance before the court.

2. Claims Submitted. As a participating Medicaid provider, Becker submitted or caused to be submitted claims for reimbursement for medical benefits provided to Medicaid patients under the Medicaid Program as administered by the State of Utah between

January 1, 1995, through October 31, 1998, (the audit/investigation period). In early 1998, Becker changed billing procedures that have apparently corrected the overpayment problem (false claims) that existed during the audit/investigation.

3. Audit/Investigation. Medicaid has conducted an audit/investigation of the claims Becker submitted or caused to be submitted during the audit period. Medicaid has determined that claims for reimbursement were submitted for services at a higher level than the actual services provided. As a result, Becker received money to which she was not entitled (overpayment).

4. No Intent. Becker asserts that there was no intentional, improper, false or wrongful billings under § 26-20-7(1),(2)(b), False Claims Act, Utah Code Ann. (1953, as amended).

TERMS OF AGREEMENT

5. Purpose. In accordance with the mutual covenants and agreements herein and with full authority to be bound thereby and in order to avoid the uncertainty and expense of litigation, the parties compromise and agree as follows:

6. Restitution, Costs of Investigation and Penalty. Becker will pay to the State of Utah $49,605.00. This payment includes full restitution by Becker of any and all overpayments

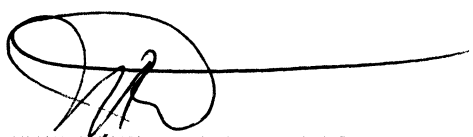
CERTIFICATE OF SERVICE

I hereby certify that on the 16th day of Sept, 2006, a true and correct copy of the foregoing BRIEF OF APPELLANT TAJ BECKER, M.D., **Appeal from the Judgment of the Fifth, District Court in and for Washington, County, State of Utah – the Honorable G. Rand Beacham,**
Civil No. 020501574/Appellate Case No. 20060495 C.A
was mailed, postage prepaid Certified Mail with Return Receipt Requested, to the following:

7004-1350-0001-8383-6100

Lyle Odendahl (#4103)
Assistant Utah Attorney General
Mark Shurtleff(#4666)
Utah Attorney General
P.O. Box 141000
Salt Lake City, UT 84114-1000
Attorneys for the Defendant
Tel: (801) 538-6878
Fax: (801) 538-6306

_____Hand Delivered
_____Mailed, overnight delivery
_____Faxed



Taj Becker, M.D., Plaintiff Pro Se

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